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Schema therapy for CBT therapists who treat borderline patients

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Abstract

Although treatment of BPD is complicated, CBT therapists can learn schema therapy (ST) principles and strategies used as an additional tool in the therapy. ST originally began as an extension of Beck's cognitive therapy model and has developed into an unique integrative treatment for the personality disorders. According to the ST principles, schemas provide in-depth understanding of personality disorders. People perceive their own self, others and world in the lenses of their schemas. A schema is an extremely stable, constant pattern which developed during childhood or adolescence and now is elaborated in individual´s life. ST also devotes considerable attention to modes, the predominant emotions, schemas, and coping reactions used by an individual at a particular time. The aim of the therapy is to engage in schema healing processes. These methods are intended to reduce the early maladaptive schemas and coping styles, and build up more adaptive and healthy approaches. A conceptualization is usually created early in the treatment. The history of the schemas, modes and coping strategies are systematically discussed, their origins explored and linked to current problems, and the opportunity of modifying is explored. In treatment phase, the therapist flexibly uses cognitive, emotional/experiential, behavioral, and relational/interpersonal strategies to change schemas and maladaptive coping styles. The therapeutic relationship is also an important part of the healing process The relationship is an area in which behaviors modes and schemas can be noticed, assessed and modified. It is also used as mediator for a "corrective emotional experience". The therapist behaves in ways that supply the unmet early needs of the patient. This connection to the childhood is mirrored in the label of this particular stance called "limited reparenting". The change of the schemas is impossible without the well-established therapeutic relationship.

Introduction

Patients suffering from borderline personality disorder (BPD) are known as difficult to work with. They show high affective instability, a proneness towards aggressive, impulsive, self-mutilating, and suicidal behavior, dissociation, unstable identity, conflicting interpersonal relations, chaotic lifestyle, high comorbidity levels, and low treatment efficacy (Latalova & Prasko 2010; Prasko *et al* 2010b; Vyskocilova *et al* 2011a). The etiology of BPD is best explained as a combination of genetic, neurobiological vulnerability combined with a childhood trauma, abuse or neglect (Hunt 2007). This combination might in some individuals lead to dysregulated emotions, distorted cognitions, social skills deficits, and insufficient adaptive coping strategies.

Clinically these patients produce numerous problems and potential therapeutic contracts. This multifaceted clinical situation can be addressed by an integrated approach to the treatment by using strategies from the different psychotherapeutic schools adapted to the particular patient (de Groot *et al* 2008; Clarkin 2012).

The currently most favorable selection and sequencing of treatment techniques are based on common therapeutic strategies (development and maintaining of the therapeutic relationship, assessment and case formulation, structured therapy, addressing problematic personality traits and sequential goals) (Clarkin 2012). Various interventions are derived from an increased emphasis on the nonspecific elements of the treatment, especially the treatment frame, case conceptualization and general interventions (Livesley 2005). Treatment options include pharmacotherapy (especially mood stabilizers, second generation antipsychotics, and antidepressants) and psychotherapeutic interventions that focus on affective regulation, distress tolerance, changing distorted beliefs, and introducing new social and relationship problem solving skills, especially during Dialectical behavior therapy, Schema therapy, and Cognitive therapy (Linehan & Kehrer 1993, Giesen-Bloo *et al* 2006; Davidson *et al* 2010).

Although treatment of BPD is complicated, many CBT therapists can learn schema therapy principles and strategies used as an additional tool in the therapy. Schema therapy is a new integrative approach based on cognitive models and offers hope for patients with BPD.

Efficacy of the schema therapy

Only one multicenter clinical RCT trial (Giesen-Bloo *et al* 2006) has been published to date, comparing the efficacy of schema therapy (ST) with psychodynamic therapy (transference focused psychotherapy – TFP). Eighty-eight subjects with BPD were randomly assigned to one of the therapies, both comprising two weekly 50-minute outpatient sessions for three years. Analyses were conducted at both first and third year. The study demonstrated that ST led to recovery from BPD in about half of the patients. Approximately two thirds of patients experienced a clinically significant improvement. ST proved to be more than twice as effective as TFP in terms of recovery rates. It not only led to a decreasing in BPD symptoms, but to long-term improvements in the patient personality traits as well. Analogous outcomes were found in psychopathology and self-reported quality of life. The dropout rates were significantly higher in TFP (50 %) than in ST (25 %). The outcomes were not significantly related related to patients' demography (i.e., age, gender, level of education or employment) or clinical features (i.e., number of comorbid diagnoses, and severity of symptoms or personality pathology) (Spinhoven *et al* 2008).

ST has been lately accommodated for different populations besides patients with BPD (e.g., homeless substance abusers or individuals with BPD or anti-social personality disorder in forensic settings; Ball *et al* 2005; Bernstein *et al* 2007). There is also a non-randomized quasi-experiment for inpatients with Cluster C personality disorders and agoraphobia who received treatment as usual or an intervention combining cognitive therapy for agoraphobia with schema therapy (Gude & Hoffart 2008).

Schema therapy framework for BPD

ST began as an extension of Beck's cognitive therapy model and has become a unique integrative treatment for the personality disorders (Young *et al* 2003; Rafaeli 2009). According to schema therapy, schemas are essential to understanding of personality disorders. A schema is an extremely stable, constant pattern which developed during childhood or adolescence and is elaborated in person´s life. People perceive themselves, others and world through their schemas (Young 1994). Schemas are core beliefs which are accepted by the person without questioning. Schemas are self-perpetuating and resistant to change. Schema therapy conceptualizes schemas differently than cognitive therapy: rather than purely cognitive in nature, they also include memories, images, emotions, and somatic sensations. Maladaptive schemas are created when basic needs are not fulfilled during childhood. The schemas then prevent corresponding needs from being satisfied in adulthood. The set of basic needs includes universal emotional needs (e.g., needs for safety, security, validation, autonomy, spontaneity, and realistic limits). The schemas emerge when basic needs are unmet or are met inappropriately (e.g., excessively). Schemas typically operate in subtle ways, out of person´s awareness. However, when a schema is triggered, person´s thoughts, feelings and behavior are subjugated to these schemas. In such situations people experience overwhelming negative emotions and have numerous dysfunctional thoughts (Young 1994).

Schema therapy proposes the taxonomy of early maladaptive schemas. Currently, there are 18 of them identified. The list includes regularly occurring ones such as defectiveness, abandonment, emotion deprivation, and subjugation, as well as the less frequent schemas.

Schema operations

There are two main schema operations: healing of schema and schema maintenance. All thoughts, emotions, and forms of behavior could be seen as a part of one of these two operations (Arntz & van Genderen 2009; Rafaeli *et al* 2010). *Schema perpetuation* is the automatized daily processes by which schemas function and maintain themselves. This is connected to cognitive errors, maladaptive behavior, and schema coping styles. The cognitive errors consist of negative interpretations of interpersonal exchanges and life events. The schemas intensify information that supports it and denies facts that contradict it (Young 1994). Likewise, destructive behavior patterns maintain the schema's existence.

Schema coping styles

There were described 3 schema coping styles: schema surrender, schema avoidance, and schema overcompensation (Young *et al* 2003; Arntz & van Genderen 2009). *The schema avoidance* refers to the ways in which people avoid triggering the schemas and subsequent pain. There are 3 ways of the schema avoidance: behavioral, cognitive, and emotional. The behavioral avoidance means that people often stay away from situations that trigger schemas. The cognitive avoidance refers to strategies that patients do not to think about upsetting events. These strategies may be either intentional or automatic. People may intentionally try not to focus on some of their personality traits or events they find upsetting. Simultaneously, there are used unconscious processes helping individuals to block out the experience which would be too disturbing to confront. People often forget especially painful events. For instance, children who were abused sexually or physically often do not remember any of this (Prasko *et al* 2012c). The emotional or affective avoidance refers to automatic or voluntary attempts to prevent painful feelings. Frequently, when patients experience painful emotions, they numb themselves in order to reduce the pain. *The schema surrender* is the way in which people submissively follow the schema. Patients do not question the schema and behave in ways that support the schema. In *the schema overcompensation* the person behaves in a way which appears to be the contradictory of what the schema suggests in order to avoid triggering of the schema. It might seem that the persons are behaving in a healthy way, by standing up for themselves. But when they overcompensate, they start to behave maladaptive, which then support the schema.

Schema modes

In addition to general *needs* and *schemas*, which are *trait-like* and persistent in their effects, schema therapy devotes considerable attention to *modes*, the predominant emotions, schemas, or coping reactions used by an individual at a particular time. The person reacts characteristically in each mode. Young observed and described a schema mode model for BPD, hypothesizing that BDP patients show a tendency to flip from 1 of 4 maladaptive schema modes to another (Young *et al* 2003). These four types of modes are: child modes, maladaptive coping modes (avoidance, over-compensation, and surrender), dysfunctional internalized parental modes (e.g., punitive or critical parental voices), and a healthy adult mode (see Young *et al* 2003, Arntz & van Genderen 2009). Some BDP patients perceive abrupt transitions (and thus deep detachment) among specific modes. Indeed, the mode concept was introduced following the realization that (trait-like) schemas leave unexplained many of the more fast-changing symptoms of patients with BPD or narcissistic personality characteristics, who experience quick and often intense shift among various mood states (Young 1994).

The history of the mode is systematically discussed; the patient talks the development of the mode and related circumstances. Associations are made between modes and contemporary problems. Arntz *et al* (2005) present the first empirical study investigating which modes are specific for BPD patients and whether BPD-relevant stress specifically increases the detached protector mode. Authors used a crossover design in which subjects subsequently watched a neutral and a BPD-specific emotional film fragments. Trait as well as state versions indicated that BPD patients were characterized

Tab. 1. Most frequent modes used by people with BPD.

MODUS	CHARACTERISATION OF THE MODE
Vulnerable / abandoned child	Function: Display helplessness, sadness, anxiety to get the needs met or call security Signs & Symptoms: Depressed, hopeless, needy, frightened, victimized, worthless, unloved, lost, frantic efforts to avoid abandonment, idealized view of nurturers
Angry / impulsive / irritable child	Function: Acts impulsively or angry to get the needs met or vents feelings in inappropriate ways, act irritable Signs & Symptoms: Intensely angry, with shouting, impulsive, demanding, devaluing, "manipulative", controlling, abusive, suicidal threats, promiscuity
Punished / Demanding parent	Function: Punishes the child for expressing the needs, feelings, behavior, display of the emotions or for making mistakes in relationships Signs & Symptoms: Self-hatred, self-punishment, self-criticism, self-denial, self-mutilation, anger at oneself for neediness
Detached protector	Function: Cuts off needs & feelings; detaches from people Signs & Symptoms: Depersonalization, emptiness, boredom, substance abuse, binging, self-mutilation, psychosomatic complaints
Hypercompensator	Function: Defends the vulnerable child by overworking, over-responsibility etc. Sign & Symptoms: Hypercompensator is competitive, ostentatiously demonstrates how much he works or controls, Fights with others, must still prove himself and others to no fall in the mode of Vulnerable/injured child
Healthy adult	Function: Understands the context, meta-position, thinks about consequences, learns new things Sign & Symptoms: Obviously interested, asking, self-reflecting

by the four maladaptive modes (Abused/Abandoned Child, Angry/Impulsive Child, Detached Protector, Punitive Parent). BPD patients were the lowest on the Healthy Adult mode. The stress induced negative emotions were also present in controls. However, the BPD group had the Detached Protector mode amplified more than controls.

In collaboration with the patient, modes get labeled, their origin is explored, they are linked to current problems, and the opportunity of modifying is explored. Following such preparations, dialogues between modes are initiated. Mode work is both cognitive and experiential in nature and is an illustration both of the integrative character of schema therapy and of its divergence from Beck's cognitive therapy (Rafaeli *et al* 2010).

Schema therapy strategies for BDP

In schema therapy, the aim of the therapy is to engage in the schema healing processes. These efforts are intended to reduce the early maladaptive schemas and coping styles, and build up the person's adaptive mode (Young *et al* 2003).

The therapy is the most effective when a collaboratively-created formulation of the case guides the selection of goals and tools in the therapy (Rafaeli 2009). The first step in conceptualization process is to create a complete assessment of the patient. The main goal of this evaluation is to recognize the schemas and coping styles that are mainly prominent in the patient's psychological makeup. Firstly, the therapist will usually need to know about current events or conditions in the patients' lives which have led them to look for help. The therapist will then discuss the patient's life experiences and look for patterns which may be connected to the schemas (Arntz & van Genderen 2009). A conceptualization is usually created early in the treatment based on an assessment period which may include structured or unstructured interviews, questionnaires, review of customer self-monitoring, and the use of imagery for assessment (Rafaeli 2009). The therapist can also use the Young Schema Questionnaire, which the patient fills in, listing the thoughts, emotions and behaviors related to the various schemas. Items in this questionnaire can be evaluated based on how appropriate to the patient's life they are (Rafaeli *et al* 2010). There are also various imagery techniques. One particular technique involves asking patients to close their eyes and produce an image of themselves as children with parents. Often the images, that arise, direct to the core schemas (Young *et al* 2003). Therapists regularly review the conceptualization with patients, and involve them in revising it in a collaborative manner.

Once the assessment/conceptualization stage is complete, the treatment enters a transformation phase whose explicit goal is for patients to be able to have their core needs met in adaptive manners. The therapist flexibly uses cognitive, emotional/experiential, behavioral, and relational/interpersonal strategies to change schemas and maladaptive coping styles with healthier forms of behavior (Kellogg 2004).

Cognitive techniques

As in the short-term cognitive therapy, the dysfunctional thoughts are recognized and described, and the indications for and against them are considered (Arntz & van Genderen 2009). Then new thoughts and beliefs are substituted. These techniques help the patient be aware of different ways to view situations. The first step in changing the schemas cognitively is to look at the evidence for and against the particular schema. This involves looking at the patient's life experiences and considering all the facts which appear to support or counter the schema. The evidence is then evaluated critically to see if it does, in fact, grant support for the schema. Usually the evidence formed will be shown to be in error, and not truly supportive of the schema (Young *et al* 2003).

Another cognitive technique is to establish a schema dialogue between the patient and the therapist. Firstly, the patient takes the side of the schema, and the therapist shows a more realistic attitude. Then the two switch sides, giving the patient an opportunity to verbalize the different point of view (Young 1994). After having several of these dialogues the patient and therapist can create a flashcard for the patient which contains a concise account of the evidence against the schema (Arntz & van Genderen 2009).

Experiential techniques

Experiential techniques are directed to change the patient perception (Arntz & van Genderen 2009). Although CBT stresses the significance of cognitions in activating or maintaining negative affect, there has been increasing accent on the role of emotional processing during experiential techniques (Prasko *et al* 2009; Prasko *et al* 2012c). Experiental techniques are therapeutic letters, role playing, imagery rescripting, and the two-or-more-chair technique.

Therapeutic letters

Many BPD patients do not understand strong emotions they experience in interpersonal situations or have no access to the core emotions (Pastucha *et al* 2009; Prasko *et al* 2011a). Writing therapeutic letters is a valid cognitive and experiential technique for work with complex emotional schemas, developed throughout the childhood (Prasko *et al* 2009). Letters are usually addressed to the important persons from the patient´s life (e.g. parents, siblings, children, a partner, and friends). The patient uses the letter to express his or her feelings and needs, including defenses of his or her rights. The patient writes the letter at home and brings it into the session. There he or she reads with the therapist. These letters are not meant to be really sent. The therapeutic goal is to process hurtful emotions. Strictly speaking,

the patient writes the letter to the *internal representation* of the close person, who was associated with the growth of the maladaptive schemas, not the person in flash. Reasons for the use of the therapeutic letters:

a. To create an experience of "a different end"
b. Cognitive reconstruction during writing and reading helps to understand processes of attribution
c. Cognitive and emotional avoidance are a maintenance factor – and writing and reading might be understood as a form of exposure which acts against the avoidant behavior
d. Exposure to the extreme emotions – step by step training to cope with them
e. Through therapeutic letters may be the patient in contact with the primary emotional states connected to the cognitive schemas

Not-censored letter – "Dirty letter" to a significant person

It is important to express the emotions in a "raw", naturalistic form. If the expression is too "soft", therapist asks the patient to produce a new, more authentic letter. Therapist helps the patient to discover the next prominent emotion in the relationship: aggression, passion, sorrow, disillusion, wish, love etc. The letters help the patient to understand that all relations, especially to the significant one, have multiple layers of emotions. The patient recalls the time when he or she was persuaded about own failure, awfulness or unlovability. The person might also be challenged to recall memories in which he or she felt inadequate or ashamed because of a mistake made – and through the notion, that "one has to be perfect and never make a mistake", thus confirmed the core belief about being a complete failure. The letter might contain all feelings, needs, exigencies, and condemnations that patient experienced in the relationship with the person. Another option is to write about things the patient to a significant person and did not. It is recommended to look for various emotional experiences: anger, contempt, envy, jealousy; pain, grief, abandon, fear and uncertainty; sorrow and guilt; love, understanding, or intimacy. "The dirty letter" to the significant person can be an opening point to work with various emotions connected to the relation:

- Anger, aggression, mistrust, jealousy, irony, punishment etc.
- Regret, sadness, loneliness, dependence
- Needs, desire
- Acceptance, friendship, collaboration, love, gentle

Letter from "the other side" (Letter to the own "hurt child")

The letter writing provides a method for locating a support, not just from the external sources, but also from the internal ones. The follow-up letter is a letter that the patient would want to receive from the important person (a parent, a sibling, a partner, a friend etc.). Rather than sending letters of disclosure to others for a response, the patient responds to the letter with what he or she feels could be the most helpfull response, thus providing self-support. Even if the person writes the letter to oneself, the process of writing can be essential for recognizing own needs. The patients might also have an opportunity to see the life events and relationship from a different point of view. The letter can also help the patient to change the maladaptive schemas. It contains secret wishes in the letter: an apology, a reason why the significant other behaved in a harmful way, a manifestation of proximity, freedom, acceptance *("you are my"),* security, love (*"I love you"*). The patient starts to build an inner ideal parent. The therapist can tell the patient along the way: "Don't be uselessly bashful and don't indulge yourself in everything you have been missing any time at your life." The patient formulates the letter to one hurt self. The letter from "the other side" can help with:

- The process of healing of the emotional traumas (often through empathy, an apologize)
- Providing acceptance ("you are my I love you...")
- Supporting the occurrence of the feelings of safety ("I am with you…")
- Reinforcing the healthy coping efforts ("You know… you cope well with…")
- Giving freedom ("you can yourself…)

"Visit-card"letter

This letter should be written from the *„healthy adult*" mode. It may be written directly, courageously, with dignity and respect to the significant other. The "visit-card" letter is:

- A letter "from adult to adult"
- Changing roles, including compromises, and empathy to the important other
- Written in the way "I am ok – you are ok"
- Supporting the proud feelings in the patient about the ability to write such content of the letter.

The letter to the "little child" of the significant person

The last letter patient writes to the close person as if this significant other was a child. The therapist usually asks the patient to bring the photos of the relevant person when being a child, for example photographs of the mother when she was about 8–10 years old. The therapist then asks patient to think what this child on picture missed from her parents. Which basic needs were not fulfilled? The patient then writes a nice, caring, protective and empathic letter to the small child. Suddenly she is not a rejecting mother anymore, but an unhappy child with unsatisfied needs. This letter helps to equalize roles between the patient and the important other.

Role playing

Role playing of a stressful situation and changing the stressful situation are valuable methods for the emotional processing applied within the cognitive behavioral therapy (Coles *et al* 2002). Instead of imagining the distressing situation the patient plays it during the therapeutic session. After the description of the child-

hood harmful or traumatic experiences, the therapist asks the patient to verbalize own opinion to the person, who mistreated the patient or didn´t help in the recent stressful situation. The aggressor or the non-helping person could be symbolized by an empty chair or by some object (Prasko *et al* 2007). The next step is the problem solving, still while role playing. Firstly, the therapist and the patient plan the best response to the traumatic or stressful event. Following the patient's instructions, the therapist plays the role of the helper. After this part they play the ideal solution of the situation. It is also possible to create other helping persons.

There are many variations of the role playing of the memories. One of the frequently used is *an inversion of the roles* (e.g. the patient plays the role of his father and the therapist plays the role of the patient as a child). The aim is to better understand the feelings of the other person and his or her behavior. Other options are an empty chair technique or, monologue.

Role playing in imagination

This emotion-centered approach assists patients to experience and express the emotional aspects of their problem. One way of this procedure is done by having patients close their eyes and imagine a dialogue with the person to whom the emotion is bound for. They are then encouraged to express these feelings as fully as possible in the imaginary conversation (Young *et al* 2003). There are many variations of the technique. The patients may take on the role of the other person in this conversation, and articulate what they imagine their feelings could have been (Arntz & van Genderen 2009).

Imagery rescripting

A childhood trauma may be accompanied by biological changes that are caused by the stressful events. Once the events take place, the range of the inner changes occurs. These changes are then long-lasting. Thought suppression, developmental regressions, deliberate avoidance, sleep problems, exaggerated startle responses, fears of the mundane, irritability, and hypervigilance are prominent among the changes. Terr (1991) describes four characteristics related to the childhood traumas that appeal to last for long periods of life. These are visualized memories of the traumatic event, trauma-specific fears, repetitive behavioral patterns, and changed attitudes about others, life, and the future. Terr divides the childhood trauma reactions into two basic types: (a) type I trauma includes memories, "omens,", and misperceptions; (b) type II trauma includes dissociation, denial, numbing, and anger.

The intention of the therapist during imagery rescripting is to improve the patient memorizing the traumatic events and expressing affective experience. Then the therapist helps the patient to rescript the experience to become less painful. The therapist helps the patient to understand, how the symptoms are connected to the events from the childhood and how they are interconnected with current life problems (Smucker & Neiderdee 1995). The therapeutic process of imagery rescripting can be divided into several steps (Prasko *et al* 2012c; Vyskocilova & Prasko 2012b):

a. Establishing of the therapeutic atmosphere (feelings of security and control, acceptance, approbation, validation of any emotions);
b. Description of the painful memories;
c. Formulating the needs of the child in this situation;
d. Discussing "the safe person" who could help the child;
e. Imagination the event rescripted with the experience of a better resolution in imagination – rescripting the story;
f. General feelings of relief.

Imagery with rescripting techniques that focus on changing unpleasant memories have also been used as main components of schema therapy programs for BDP (Giesen-Bloo *et al* 2006; Weertman & Arntz 2007), in bulimia nervosa (Ohanian 2002), snake phobia (Hunt & Fenton 2007), OCD (Prasko 2010), for posttraumatic stress disorder arising from the childhood sexual abuse (Smucker & Neiderdee 1995), and for depression (Wheatley *et al* 2007; Brewin *et al* 2009).

Behavioral techniques

In behavioral techniques the therapist assists the patient in changing long-term behavior patterns so that schema surrender behaviors are decreased and healthy coping reactions are developed (Arntz & van Genderen 2009).

One behavioral strategy is teaching patients better communication skills (Vyskocilova & Prasko 2012c). For instance, a patient with a Subjugation schema believes that he deserves a pay raise at work but does not know how to ask for it (Young & Klosko 1993). One possible approach is role-playing. Firstly, the therapist plays the patient´s role and the patient takes the role of the supervisor. This allows the therapist to demonstrate how to get the request appropriately. Then the patient gets an opportunity to practice the new behavior and to gather the feedback from the therapist before changing the behavior in the real life situations.

Interpersonal techniques

Interpersonal techniques highlight the patient's interactions with other persons so that the role of the schemas can be exposed. This might be done by focusing on the relationship with the therapist.

Therapeutic relationship in schema therapy

Numerous experiential, interpersonal, cognitive, and behavioral methods and techniques could be used in the treatment of patients with BPD. However, if the therapeutic relationship is not developed sufficiently, the change is not possible (Arntz & van Genderen 2009;

Prasko *et al* 2011b). The biggest threat to the successful treatment is the reaction of severe personality disordered patients, who lack an integrated sense of self and suffer from intense, fluctuating emotions that challenge an inexperienced, reactive therapist (Clarkin 2012). By integrating cognitive behavioral therapy with the ideas from the attachment models object relations theory, Gestalt therapy and transactional analysis, schema therapy differs from the classic cognitive therapy in additional respects (Rafaeli *et al* 2010). One difference is in the therapist's role. While classic cognitive therapists typically view the relationship as a vehicle for motivating patients' engagement (e.g., with homework assignments), schema therapists use the relationship quite extensively, in two main ways. Firstly, it is an area in which the behaviors modes, and schemas can be observed, assessed, and modified. Secondly, the relationship is used as "a corrective emotional experience". Through "the limited reparenting," the therapist acts in ways that supply early unmet needs. Limited reparenting involves a flexible ability to partially meet the patient's basic emotional needs – after determining what those needs are – and through that, to model a healthy adult approach that the patient may internalize. The unmet childhood needs are fulfilled, within the correct boundaries of the therapeutic relationship. Practically, it calls for warmth, acceptance, caring and validation, often exceeding those present in cognitive therapy (let alone non-cognitive behavioral approaches). For example, phone calls or emails are encouraged as to be an appropriate therapist self-disclosure. The therapist has to be actively conscious of the plenty of rapidly changing factors that play a role in the patient´s problems, and at the same time has to address them. Essential for the therapeutic relationship is the idea of "limited reparenting" (Young 1994; Young *et al* 2003).

The main therapeutic stance of schema therapy is an empathic confrontation, not collaborative empiricism. Therapists empathize with patients and confirm the developmental factors that led to their schema view, while confronting them with the reality that the schemas are maladaptive and do not fit well with reality.

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